...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

7-1-98

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
unable to work as many hrs.
or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
00	6	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-1 19 98 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

[illegible] LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

FAXED 8-1-98

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	7	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-1-98 19 ___ Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 516.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	8	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 9-1 19 98 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecut: months earnings to determine this average.

5. My monthly income for each month for which claim is being m follows:

Amount	Month	Year	Amount	Month	Year
00	9	98			

Any information necessary to verify the answers I have give will be furnished upon request.

Date 10-1 19 98 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 5166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	10	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 11-2 19 98 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 516.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	11	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 12-1 19 98 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

[illegible] LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1000.00	12	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 1-4 19 99 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

[illegible] LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$500.00	1	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 2-1 19 99 Signed Christopher L Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 1000.00	2	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 3-3 19 99 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

Jefferson-Pilot Financial
Individual Health Claims (4170)
Supplemental Claimant's Statement For Residual Disability Benefits

Name in Full CHRISTOPHER KEARNEY Policy No. H-538069 H-493029

1. I was residually disabled from 2-8 19 93 To present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____ Or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES, OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which a claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
00	3	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 4-6- 19 99 Signed Christoph Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H538069

Name in Full CHRISTOPHER KEARNEY Policy No. H493029

1. I was residually disabled from 2-8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
00	4	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 5-1 19 99 Signed Christopher L. Kearney (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$00.00	5	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 6-14 19 99 Signed Christopher L. Kearney (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
00	6	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-5 19 99 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	7	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-1 19 99 Signed Christopher L. Kearney (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538064

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not done 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 00	8	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 9-1 19 99 Signed Christopher L. Kearney (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not done 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
00	9	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10-1 19 99 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not done 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ____ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1000.00	9	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10-1-99 19 ___ Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (4170)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 493029

1. I was residually disabled from 2/8 19 93 to present 19 ___

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
11-30-99	00	'99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 11-30-99 19 ___ Signed Christoph Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (5315)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H 538069 H 493029

1. I was residually disabled from _____ 19 93 to present 19 __.

2. During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 __.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (whichever is greater) was $ 8166 (to the nearest dollar).

I used the (A) ✓ prior calendar year (B) _____ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 2000.00	12	99						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 12-30 19 99 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT. BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (5315)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Policy No. H 538069 H 493029

1. I was residually disabled from _____ 19 93 to present 19___.

2. During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (whichever is greater) was $ 8166.00 (to the nearest dollar).

I used the (A) ✓ prior calendar year (B) _____ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
# 2000.00	1	2000						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 2-1-2000 ~~19~~ ___ Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT. BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (5315)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Policy No. H 538069 H 493029

1. I was residually disabled from _____ 1993 to present 19__.

2. During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19__.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (whichever is greater) was $ 8166 (to the nearest dollar).

I used the (A) ✓ prior calendar year (B) _____ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	1	2000						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 3-1 19 2000 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT. BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L KEARNEY Policy No. H.493029/H.538069

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1000.00	3	2000						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 3-31 19 2000 Signed Christopher L Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.